

Membership Record and Employer Certification of Eligibility

State Form 34413 (R5/09-12-2002)

PRIVACY NOTICE

All Social Security Numbers are requested by this agency in accordance with the requirements of the Internal Revenue Code. Disclosure is mandatory and this form will not be processed without this information.

INSTRUCTIONS:

Please print or type in black ink.

Please forward the completed form to the Public Employees' Retirement Fund within five (5) days of the member's date of employment.

You are required to submit a copy of the employee's Social Security Card with this form. If you do not submit a copy of their Social Security Card, this form will not be processed.

ENROLLMENT INFORMATION (To be completed by the Employer)

Social Security Number _ _ _ - _ _ - _ _		Date of Birth (mm/dd/yyyy)	
First Name	MI	Last Name	
Address			
City		State	Zip Code
Home Telephone Number		Other Telephone Number	
E-mail Address			
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		CURRENT MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
<p>I certify that the individual named in this record is employed in an approved PERF-covered position. I understand that submission of this membership record creates a pension liability on the part of this employer and that employer and employee contributions must begin with the date of hire.</p> <p>I certify that I am the individual formally authorized to accept said liability for and on behalf of the governing body of this employer, and that the date of employment listed below is correct.</p>			
Date of Employment in this Position (mm/dd/yyyy)		Date Employer Contributions Will Begin (mm/dd/yyyy)	
Position or Title		Name of Employer	
Address			
City		State	Zip Code
Employer Phone Number		Employer Account Number	
Signature of Authorized Agent		Printed Name of Authorized Agent	

Member Name (Last, First, Middle Initial)	Social Security Number _ _ _ - _ _ - _ _
---	---

BENEFICIARY INFORMATION (To be completed by the Employee)
 Attach Additional Copies of this Page if Necessary

Primary Beneficiary or Beneficiaries

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

Contingent Beneficiary or Beneficiaries

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

In accordance with the provisions of Indiana Code § 5-10.2-3, I designate my beneficiary or beneficiaries as shown above. If the primary beneficiary or beneficiaries herein designated survive me, they shall receive the funds, if any, that are payable by the fund to a designated beneficiary. If the primary beneficiary or beneficiaries do not survive me then the contingent beneficiary or beneficiaries shall receive such funds. If none survive me, then the beneficiary shall be my estate. If no designation is made, any death benefit due would be payable to my estate. I reserve the right to change the primary or contingent beneficiaries at any time prior to retirement by filing a Change of Beneficiary form with the Board of Trustees of the Fund. Such a change must be received and accepted by the fund prior to my death for it to become effective.

I understand that this designation of beneficiary supersedes and replaces any prior designation of beneficiary that may have been made in the course of this or any prior employment in a PERF-covered position with any other employer.

Signature of Member	Printed Name
---------------------	--------------

Member Name (Last, First, Middle Initial)

Social Security Number

____ - ____ - ____

PRIOR EMPLOYMENT HISTORY (To be completed by the Employee)

Please list all prior employment with any other PERF employer, including the State of Indiana, or any city, town, school district, township, or other unit of local government located in the state of Indiana for which you believe you may be entitled to service credit with the Public Employees' Retirement Fund. Attach additional sheets if necessary.

Employer Name	Position Title	Start Date	Termination Date
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____
		__ / __ / ____	__ / __ / ____

Member Certification

I certify that the information I have provided in this record is, to the best of my knowledge, accurate and complete.

Signature of Member

Printed Name

**Employer Certification of Creditable
Service and Authorized Leave**

State Form 3422 (R10/02-2002)

PRIVACY NOTICE

All Social Security Numbers are requested by this agency in accordance with the requirements of the Internal Revenue Code. Disclosure is mandatory and this form will not be processed without this information.

Employee's Name: Last, First, Middle Initial

Employee Social Security Number

_ _ _ - _ - _ - _ _

Part 1: Active Service and Paid Leave

List current or most recent position first. If the PERF-covered employment was continuous, complete only the first line below. However if the employee terminated employment and was re-hired in a PERF-covered position, you should list each different period of covered employment. You should also include all periods of **paid** authorized leave here.

Title of PERF-covered Position (Use a separate line for each position)	Beginning Date of Employment			Last Day in Pay Status		
	Month	Day	Year	Month	Day	Year

Part 2: Authorized Unpaid Leave

Please list all periods of authorized unpaid leave. This would include (but is not limited to) maternity leave, FMLA leave, military leave, and employer provided disability leave/programs.

Type of Authorized Unpaid Leave (Use a separate line for each leave)	Beginning Date of Leave			Ending Date of Leave		
	Month	Day	Year	Month	Day	Year

The position(s) identified and certified above are PERF-covered position(s) in accordance with the agreement(s) between PERF and the governing body of the employer. I certify that the above dates are true and accurate to the best of my knowledge and that I am the individual formally authorized to accept any pension liability for and on behalf of the governing body of this employer. I understand that the verification of the above referenced periods of service and authorized leave create a pension liability for this employer. ANY ERROR IN THIS CERTIFICATION OF SERVICE CAN ONLY BE CORRECTED PRIOR TO THE EMPLOYEE'S EFFECTIVE DATE OF RETIREMENT.

Signature of Authorized Individual	Printed Name of Authorized Individual
Title of Authorized Individual	Date
Name of Employer	Employer Account Number